Supporting Statement – Part A

Minimum Essential Coverage
(CMS-10465/OMB Control Number: 0938-1189)

A. Background

The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010 (collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets.

Section 1501 of the Affordable Care Act adds section 5000A to the Internal Revenue Code (IRC), which requires that individuals maintain minimum essential coverage, qualify for an exemption, or make a shared responsibility payment with their federal income tax return. Under the Tax Cuts and Jobs Act, which was enacted on December 22, 2017, the individual shared responsibility payment was reduced to $0, effective for months beginning after December 31, 2018.[1] IRC section 5000A(f) designates certain types of coverage as minimum essential coverage. In addition, IRC section 5000A(f)(1)(E) directs the Secretary of Health and Human Services (HHS), in coordination with the Secretary of the Treasury, to recognize other health benefits coverage as minimum essential coverage for purposes of their enrollees satisfying the minimum coverage requirement. The final rule titled "Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions" published July 1, 2013 (78 FR 39494) designates certain types of existing coverages as minimum essential coverage. Other coverages, not statutorily designated and not designated as minimum essential coverage in regulation, may be recognized as minimum essential coverage if certain substantive and procedural requirements are met.

B. Justification

1. Need and Legal Basis

The final rule specifically designates certain types of coverage, which have not been designated in the statute, as minimum essential coverage. In addition, the final rule outlines a process by which other types of coverage can seek to be recognized as minimum essential coverage. To be recognized as minimum essential coverage, the coverage must offer substantially the same consumer protections as those enumerated in the Title I of Affordable

[1] Although the individual shared responsibility payment was reduced to $0, several important consumer protections continue to exist for individuals who are enrolled in coverage that is recognized as MEC, that do not exist for individuals who are enrolled in non-MEC plans. For example, individuals who lose MEC are entitled to a special enrollment period (SEP) during which they can request enrollment in individual market health insurance coverage any time between 60 days before and 60 days after losing that coverage, instead of being able to request enrollment in such coverage only during the annual open enrollment period each year. Also, eligibility for certain other SEPs are contingent upon an individual having prior MEC, such as the SEPs for individual health insurance coverage that are created upon marriage, and upon gaining access to new individual health insurance plans as a result of a permanent move (45 CFR 155.420, 45 CFR 147.104).

Care Act relating to non-grandfathered, individual health insurance coverage to ensure consumers are receiving adequate coverage.

The final rule requires sponsors of other coverage that seek to have such coverage recognized as minimum essential coverage to adhere to certain procedures. They will have to submit to HHS electronically the following information: (1) name of the organization sponsoring the plan; (2) name and title of the individual who is authorized to make, and makes, this certification on behalf of the organization; (3) address of such individual; (4) phone number of such individual; (5) number of enrollees; (6) eligibility criteria; (7) cost sharing requirements, including deductible and out-of-pocket maximum; (8) essential health benefits covered; and (9) a certification that the plan substantially complies with the provisions of Title I of the Affordable Care Act applicable to non-grandfathered individual health insurance coverage and any plan documentation or other information that demonstrate that the coverage sponsored by the organization substantially complies with these provisions.

The final rule also requires that sponsors whose health coverage are recognized as minimum essential coverage will have to provide a notice to enrollees informing them that the plan has been designated minimum essential coverage. The notice requirement may be satisfied by inserting a statement into existing plan documents. Plan documents are usually reviewed and updated annually before a new plan year begins. Sponsors may insert the statement in their plan documents at that time at minimal cost. Once the notice is included in plan documents in the first year, no additional cost will be incurred in future years.

2. Information Users

CMS will need the information in this collection to determine whether the plan sponsored by the requesting sponsor may be recognized as minimum essential coverage. CMS will maintain a public list of the types of coverage that have submitted this information and have been determined by the Secretary to meet the requirements to be recognized as minimum essential coverage. Consumers will also need to know that the types of coverage they are enrolled in are recognized as minimum essential coverage.

3. Use of Information Technology

Requesting sponsors are expected to submit the information to CMS electronically.

4. Duplication of Efforts

There is no duplication of efforts.

5. Small Businesses

Small businesses are not affected by this collection.

6. Less Frequent Collection

This information will be provided to CMS at the time of the initial request and if there are any changes to the coverages at a later date. If sponsors do not submit this information, CMS will not be able to determine whether these types of coverage may be recognized as minimum essential coverage. In addition, if consumers are not provided with a notice of

minimum essential coverage status, they would not be aware that the types of coverage in which they are enrolled are recognized as minimum essential coverage.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

A Federal Register notice was published on April 12, 2022 (87 FR 21660), providing the public with a 60-day period to submit written comments on the information collection requirements (ICRs). No comments were received. A 30-day notice published in the Federal Register on September 1, 2022.

9. Payments/Gifts to Respondents

No payments or gifts are associated with these ICRs.

10. Confidentiality

CMS will protect privacy of the information provided to the extent provided by law.

11. Sensitive Questions

These ICRs involve no sensitive questions.

12. Burden Estimates (Hours & Wages)

Organizations that currently provide other types of health coverage that are not designated by statute or regulation as minimum essential coverage may submit a request to CMS that their coverage be recognized as minimum essential coverage. Organizations that make substantial changes to health coverage previously recognized as minimum essential coverage must also reapply for continued recognition of their coverage. Sponsors will have to electronically submit to CMS information regarding their plans and certify that their plans meet substantially all of the requirements in the Title I of Affordable Care Act applicable to non-grandfathered, individual health insurance coverage. We anticipate that, on average, 10 sponsors will submit such a request each year. Average labor costs (doubled to include fringe benefits and other associated costs) are calculated using data available from the Bureau of Labor Statistics.[2]

Adjusted Hourly Wages Used in Burden Estimates

[2] May 2020 Occupational Employment Statistics found at https://www.bls.gov/oes/current/oes_nat.htm). To account for fringe and overhead, HHS is using 100% of the mean hourly wage.

Occupation Title	Occupational Code	Mean Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
Secretaries and Administrative Assistants, Except Legal, Medical, and Executive	43-6014	$19.43	$19.43	$38.86
Human Resources Manager	11-3121	$64.70	$64.70	$129.40
Lawyer	23-1011	$71.59	$71.59	$143.18
Chief Executives	11-1011	$95.12	$95.12	$190.24

The burden associated with this certification includes the time needed to collect and submit the necessary plan information and to retain a copy for recordkeeping by clerical staff and for a manager and legal counsel to review it and for a senior executive to review and sign it. The certification and attachments will be submitted to CMS electronically at minimal cost. We estimate that it will take a combined total of 5.25 hours (4 hours for clerical staff at an hourly cost of $38.86, 0.5 hours for a human resource manager at an hourly cost of $129.40, 0.5 hours for legal counsel at an hourly cost of $143.18 and 0.25 hours for a senior executive at an hourly cost of $190.24) to prepare and submit the information and certification to CMS and to retain a copy for recordkeeping purposes. The total cost for one sponsor is estimated to be approximately $339. The sponsor will need to submit this certification to CMS only once and will need to resubmit it only if there is any change in coverage. Therefore, the total burden for 10 sponsors will be 52.5 hours, with an equivalent cost of approximately $3,393.

Table 12.1 Estimated Burden Hours for Minimum Essential Coverage Certification

Type of Form	**Number of Respondents**	**Number of Reports**	**Total Estimated Burden Hours**	**Burden Cost Per Respondent**
Certification	10	1	52.5	$339

13. Capital Costs

Sponsors are not expected to incur capital costs to fulfill these requirements.

14. Cost to Federal Government

CMS staff is expected to review the information submitted by requesting sponsors. We anticipate that a reviewer will need 3 hours to review each submission.

Table 14.1 Estimated Cost to Federal Government

Type of Federal Employee Support	Total Burden Hours per Reviewer	Total Reviewers	Hourly Wage Rate (GS 14 equivalent) – (includes fringe)	Total Federal Government Costs
Review of MEC Application Materials	30 hours	1	$120.98	$ 3,629

Hourly rate is based on a 14 Grade/Step 1 in the Washington DC area.

15. Changes to Burden

There are no changes in burden hours. However, updated labor costs have resulted in an increase in equivalent costs from $3,167 to $3,393.

16. Publication/Tabulation Dates

CMS publishes a list of those plans that have applied for and received MEC recognition at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/minimum-essential-coverage.html.

17. Expiration Date

The expiration date will be displayed on the first page of each instrument (top, right-hand corner).